Third Party Services:
Fiscal and Support Services,
Cash and Counseling Program
06-X-38314

APPENDICES

Appendix 1 – Cash Management Plan

Appendix 2 – Completed Cash Management Plan

Appendix 3 – Counselor/Participant Matches

Appendix 4 – Quarterly Report

APPENDIX 1 - CASH MANAGEMENT PLAN

Cash Management Plan

as given to

Participants

DIVISION OF DISABILITY SERVICES
PERSONAL PREFERENCE PROGRAM
Cash Management Plan

Consumer Name: _____ Cash Grant Amount: _____

Representative Name: _____ Medicaid #: _____

Type of Plan: (check one) Initial ☐ Revision ☐ Reassessment ☐ Start Date: _____

(# hours/wk x 4.33)

I. Direct Employment

Service Type/Description	Worker	Hourly Wage	Total Taxes Per Hour	Sum of Hourly Wages & Taxes	# of Hours Per Month	Total Monthly Cost
Domestic Household Employee						$ -
						$ -
back-up						$ -
						$ -
						$ -
				Total Monthly Employment Costs		$ -

II. Purchase of Agency Services

Service Type/Description	Agency Name	Frequency	Unit Cost	Number of Units Per Month	Total Monthly Cost
					$ -
					$ -
					$ -
				Total Monthly Agency Services Costs	$ -

III. Miscellaneous Expenses

Expense Type/Description	Provider Description	Frequency	Unit Cost	Total Monthly Cost
				$ -
				$ -
Cash				$ -
				$ -
				$ -
				$ -
Home / Workers Comp Insurance				$ -
			Total Monthly Miscellaneous Costs	$ -

Agency name: _____ Policy# _____

Effective Date: _____

Consumer Name: _____ Medicaid #: _____

Representative Name: _____

IV. Special Purchases/Modifications

Description of Work/Purchase	Contractor/Provider Name	Proposed Purchase Date	Estimated Cost	Estimated # of Monthly Payments	Total Monthly Cost

Comments:

Total Monthly Special Purchase/Modification Costs $ -

V. Fiscal Intermediary Services & Fees

Description of Services and Fees	# of Units	Unit Cost	Total Monthly Cost
			$ -
			$ -
Transaction Fees		$ 0.75	$ -
Criminal Background Investigation Fee			$ -
Employee Health Insurance			$ -

Comments:

Total Monthly Fiscal Intermediary Costs $ -

Consumer Name: _____ Medicaid #: _____

Representative Name: _____

RECONCILIATION OF MONTHLY CASH BENEFIT

		Monthly Amount
A. Total Monthly Cash Benefit		$ -
B. LESS Cost of Direct Employment	(Section I)	$ -
C. LESS Cost of Agency Services	(Section II)	$ -
D. LESS Cost of Other Expenses	(Section III, IV)	$ -
E. LESS Cost of Fiscal Intermediary Services	(Section V)	$ -
(A minus the sum of B, C, D & E)	MONTHLY BALANCE	$ -

CMP Designed By:

Consumer Signature: _____ Date: _____

Representative Signature: _____ Date: _____

Consultant Review: _____ Date: _____

(Signature and Title)

Agency Name: _____ Phone# _____

State Program Office Approval: _____ Date: _____

(Signature and Title)

PPPcmp 7/99:8/99:8/02 Revision#

Comments:

DIVISION OF DISABILITY SERVICES

Personal Preference Program

Instructions for Completing the Cash Management Plan

Please read through the directions carefully before entering information. If you have questions concerning the completion of the Plan please contact your Consultant.

Please complete the identifying information at the top of the first page of the Cash Management Plan as well as on pages two and three. Please check whether the plan is the Initial Plan or a Revised Plan, and if it was triggered by a Nursing Reassessment that resulted in a change.

SECTION I: DIRECT EMPLOYMENT

Service Type/Description: List all services you would like to receive through individual workers who will be directly hired and supervised by you, as the consumer.

Worker: List the name of the individual worker or workers you would like to employ to provide the services you need in this section. You should also list any worker that you would like to use as a back up so that they may be able to receive a pay check for future services provided. Indicate in this section whether the worker(s) listed will be a regular employee or a back up. *Please note*: the back-up worker wages and taxes are not to be counted in towards your total monthly costs.

Hourly Wage: List the hourly wage that you intend to pay each worker listed above.

Total Taxes Per Hour: Indicate the total hourly tax expense for each wage listed above. You may obtain this information from Community Access Unlimited (CAU), the Fiscal Intermediary by calling 1-877-354-9944, or refer to the Tax Chart at the end of these instructuions.

Sum of Hourly Wages/Taxes: List the sum of the hourly wage and hourly tax expense for each worker listed.

Number of Hours Per Month: Multiply the number of hours per week you intend to hire each worker by 4.33.

Total Monthly Cost: Multiply the hourly wage and taxes by the number of hours per month to obtain the total cost per month for each worker you hire.

Total Monthly Employment Costs: Indicate the sum of the total cost per month for all workers hired.

SECTION II: PURCHASE OF AGENCY SERVICES

Service Type / Description: List all services you would like to receive through an agency. You should also indicate any agency that you would like to consider using as a back up. Please note: the back-up agency costs are not to be counted in towards your total monthly costs.

Agency Name: List the name of the agency you would like to use to provide the service listed.

Frequency: Indicate the frequency in which each service is purchased every month.

Unit Cost: List the unit cost you intend to pay for each service listed.

Number of Units Per Month: List the number of units of service per month you intend to purchase. For example, housekeeping service twice per month would be considered 2 units per month.

Total Monthly Cost: Multiply the number of units per month by the unit cost for each agency you plan to use.

Total Monthly Agency Services Costs: Indicate the sum of the total cost per month for all agencies listed, with the exception of backup agencies as previously stated.

SECTION III: MISCELLANEOUS EXPENSES

Expense Type / Description: List all other expenses you plan to have each month. Please note: you will need to include homeowner or renter's insurance or a rider to your insurance as regular expense to guarantee that your workers are covered for worker's compensation.

On the line that says "Cash" write the amount you will need in cash each month to buy things, such as supplies not covered under Medicaid or taxi fare. Remember, this amount cannot exceed 10% of your total cash grant amount.

Provider Description: Indicate the intended provider for each expense listed above. Describe any item or service you will purchase next to the cash line but under the provider description category.

Frequency: Indicate the frequency each expense item will occur every month.

Unit Cost: List the unit cost you intend to pay for each miscellaneous expense.

Total Monthly Cost: Indicate the total monthly cost for each individual expense.

Total Monthly Miscellaneous Costs: Indicate the sum of the total cost for all expenses listed above.

SECTION IV: SPECIAL PURCHASES / MODIFICATIONS

Description of Work / Purchase: List all one-time purchases, modifications or services you intend to buy through your Cash Management Plan. This includes all contractual work (modifications) you plan for your home.

Contractor / Provider Name: Indicate the name of the contractor or provider you intend to use for the work/purchase indicated.

Proposed Purchase Date: Indicate the month and year you expect to make each purchase listed.

Estimated Cost: Indicate the approximate total cost of each purchase listed above.

Estimated # of Monthly Payments: Indicate how many months it will require to pay for each purchase or modification listed.

Total Monthly Cost: Indicate the total monthly cost for each purchase or modification listed. (This figure should represent the estimated cost divided by the estimated # of monthly payments). This number indicates the amount of the monthly payment(s).

Total Monthly Special Purchase/Modification Costs: Indicate the sum of the total monthly cost for all expenses listed above under this section.

SECTION V: FISCAL INTERMEDIARY SERVICES & FEES

Description of Services and Fees: Indicate the type(s) of service(s) provided by the Fiscal Intermediary Service Organization (for instance, background investigation fees, employee health insurance fees, etc.).

# of Units: Indicate the number of units to be charged to your grant for each type of fee that is used.

Unit Cost: Indicate the unit cost for each fee type that is used. This information can be obtained by contacting the Fiscal Intermediary Organization.

Total Monthly Cost: Indicate the total monthly expense for each fee type by multiplying the number of units times the unit cost.

Total Monthly Fiscal Intermediary Costs: Indicate the sum of the total cost for all expenses listed above by adding them together to obtain the Total Monthly Fiscal Intermediary Expenses.

RECONCILIATION OF MONTHLY CASH BENEFIT

A. Total Monthly Cash Benefit: Indicate the amount of your total monthly budget as identified on page one of your Cash Management Plan.

B. Direct Employment Expenses: Indicate the total amount of expenses for the workers that you are employing directly.

C. Agency Purchase of Service Expenses: Indicate the total amount of expenses for services that you are purchasing through agencies.

D. Miscellaneous Expenses, Special Purchases/Modifications: Indicate the budgeted amount of the cash grant that is set aside for future one-time purchases, modifications, or for cash.

E. Fiscal Intermediary Expenses: Indicate the total amount of expenses for bookkeeping and other business related costs under the Fiscal Intermediary.

MONTHLY BALANCE: Subtract the expenses listed in B, C, D, and E, from the Total Monthly Cash Benefit (A) amount indicated above. In completing this calculation, your Monthly Balance should be as close to "0" as possible without having a negative balance. Any extra funds will be kept in your account.

Please sign, or ask your representative to sign and date your Cash Management Plan.

Carefully review the Cash Management Plan for accuracy and return it to your Consultant for their review and signature. The State Program Office will call you if they have any questions. Your Plan will not go into effect until you get approval from the State Program Office. Plans are reviewed by your consultant and given final approval by the State Program Office. Please do not make any purchases until your plan has been approved by the State Program. Any purchases made without approval will be your financial responsibility.

Instcmp1: 6/99:7/99:8/99:8/6/99:8/10/99:8/16/99:11/12/99:8/02:6/03

PAY RATE	TAX
$ 8.00	$ 1.16
$ 8.05	$ 1.17
$ 8.10	$ 1.17
$ 8.15	$ 1.18
$ 8.20	$ 1.19
$ 8.25	$ 1.20
$ 8.30	$ 1.20
$ 8.35	$ 1.21
$ 8.40	$ 1.22
$ 8.45	$ 1.23
$ 8.50	$ 1.23
$ 8.55	$ 1.24
$ 8.60	$ 1.25
$ 8.65	$ 1.25
$ 8.70	$ 1.26
$ 8.75	$ 1.27
$ 8.80	$ 1.28
$ 8.85	$ 1.28
$ 8.90	$ 1.29
$ 8.95	$ 1.30
$ 9.00	$ 1.31
$ 9.05	$ 1.31
$ 9.10	$ 1.32
$ 9.15	$ 1.33
$ 9.20	$ 1.33
$ 9.25	$ 1.34
$ 9.30	$ 1.35
$ 9.35	$ 1.36
$ 9.40	$ 1.36
$ 9.45	$ 1.37
$ 9.50	$ 1.38
$ 9.55	$ 1.38
$ 9.60	$ 1.39
$ 9.65	$ 1.40
$ 9.70	$ 1.41
$ 9.75	$ 1.41
$ 9.80	$ 1.42
$ 9.85	$ 1.43
$ 9.90	$ 1.44
$ 9.95	$ 1.44

PAY RATE	TAX
$ 10.00	$ 1.45
$ 10.05	$ 1.46
$ 10.10	$ 1.46
$ 10.15	$ 1.47
$ 10.20	$ 1.48
$ 10.25	$ 1.49
$ 10.30	$ 1.49
$ 10.35	$ 1.50
$ 10.40	$ 1.51
$ 10.45	$ 1.52
$ 10.50	$ 1.52
$ 10.55	$ 1.53
$ 10.60	$ 1.54
$ 10.65	$ 1.54
$ 10.70	$ 1.55
$ 10.75	$ 1.56
$ 10.80	$ 1.57
$ 10.85	$ 1.57
$ 10.90	$ 1.58
$ 10.95	$ 1.59
$ 11.00	$ 1.60
$ 11.05	$ 1.60
$ 11.10	$ 1.61
$ 11.15	$ 1.62
$ 11.20	$ 1.62
$ 11.25	$ 1.63
$ 11.30	$ 1.64
$ 11.35	$ 1.65
$ 11.40	$ 1.65
$ 11.45	$ 1.66
$ 11.50	$ 1.67
$ 11.55	$ 1.67
$ 11.60	$ 1.68
$ 11.65	$ 1.69
$ 11.70	$ 1.70
$ 11.75	$ 1.70
$ 11.80	$ 1.71
$ 11.85	$ 1.72
$ 11.90	$ 1.73
$ 11.95	$ 1.73

PAY RATE	TAX
$ 12.00	$ 1.74
$ 12.05	$ 1.75
$ 12.10	$ 1.75
$ 12.15	$ 1.76
$ 12.20	$ 1.77
$ 12.25	$ 1.78
$ 12.30	$ 1.78
$ 12.35	$ 1.79
$ 12.40	$ 1.80
$ 12.45	$ 1.81
$ 12.50	$ 1.81
$ 12.55	$ 1.82
$ 12.60	$ 1.83
$ 12.65	$ 1.83
$ 12.70	$ 1.84
$ 12.75	$ 1.85
$ 12.80	$ 1.86
$ 12.85	$ 1.86
$ 12.90	$ 1.87
$ 12.95	$ 1.88
$ 13.00	$ 1.89
$ 13.05	$ 1.89
$ 13.10	$ 1.90
$ 13.15	$ 1.91
$ 13.20	$ 1.91
$ 13.25	$ 1.92
$ 13.30	$ 1.93
$ 13.35	$ 1.94
$ 13.40	$ 1.94
$ 13.45	$ 1.95
$ 13.50	$ 1.96
$ 13.55	$ 1.96
$ 13.60	$ 1.97
$ 13.65	$ 1.98
$ 13.70	$ 1.99
$ 13.75	$ 1.99
$ 13.80	$ 2.00
$ 13.85	$ 2.01
$ 13.90	$ 2.02
$ 13.95	$ 2.02

PAY RATE	TAX
$ 14.00	$ 2.03
$ 14.05	$ 2.04
$ 14.10	$ 2.04
$ 14.15	$ 2.05
$ 14.20	$ 2.06
$ 14.25	$ 2.07
$ 14.30	$ 2.07
$ 14.35	$ 2.08
$ 14.40	$ 2.09
$ 14.45	$ 2.10
$ 14.50	$ 2.10
$ 14.55	$ 2.11
$ 14.60	$ 2.12
$ 14.65	$ 2.12
$ 14.70	$ 2.13
$ 14.75	$ 2.14
$ 14.80	$ 2.15
$ 14.85	$ 2.15
$ 14.90	$ 2.16
$ 14.95	$ 2.17
$ 15.00	$ 2.18
$ 15.05	$ 2.18
$ 15.10	$ 2.19

APPENDIX 2 - COMPLETED CASH MANAGEMENT PLAN

Example of a completed

Cash Management Plan

Attached is an example of a completed Cash Management Plan. However, personal information has been blanked out. Therefore, the participant's name, Medicaid #, employee (worker) name, consumer (participant) name, counselor name, and counseling agency name have been blanked out.

STATE OFFICE ON DISABILITY SERVICES
PERSONAL PREFERENCE PROGRAM
Cash Management Plan

Consumer Name: [redacted] **Cash Grant Amount:** $966.46

Representative Name: _____ **Medicaid #:** [redacted]

Type of Plan: (check one) Initial [ ] Revision [6] Reassessment [x] **Start Date:** October-00

revised 2/26/02 effective 3/1/02

I. Direct Employment

Service Type/Description	Worker	Hourly Wage	Total Taxes Per Hour	Sum of Hourly Wages & Taxes	# of Hours Per Month	Total Monthly Cost
Domestic Household Employee		$ 10.00	$ 1.45	$ 11.45	77.94	$ 892.41
Back-up						$ -
						$ -
						$ -
						$ -
				Total Monthly Employment Costs		$ 892.41

II. Purchase of Agency Services

Service Type/Description	Agency Name	Frequency	Unit Cost	Number of Units Per Month	Total Monthly Cost
					$ -
					$ -
					$ -
				Total Monthly Agency Services Costs	$ -

III. Miscellaneous Expenses

Expense Type/Description	Provider Description	Frequency	Unit Cost	Total Monthly Cost
				$ -
				$ -
Cash	Transportation	14	$ 5.00	$ 70.00
				$ -
				$ -
				$ -
Home / Workers Comp Insurance				$ -
			Total Monthly Miscellaneous Costs	$ 70.00

Consumer Name: _____ Medicaid #: _____

Representative Name: 0

IV. Special Purchases/Modifications

Description of Work/Purchase	Contractor/Provider Name	Proposed Purchase Date	Estimated Cost	Estimated # of Monthly Payments	Total Monthly Cost
				Total Monthly Special Purchase/Modification Costs	$ -

V. Fiscal Intermediary Services & Fees

Description of Services and Fees	# of Units	Unit Cost	Total Monthly Cost
			$ -
			$ -
Transaction Fees	5	$ 0.75	$ 3.75
Criminal Background Investigation Fee			$ -
Employee Health Insurance			$ -
		Total Monthly Fiscal Intermediary Costs	$ 3.75

Consumer Name: _____ Medicaid #: _____

Representative Name: 0

RECONCILIATION OF MONTHLY CASH BENEFIT

		Monthly Amount
A. Total Monthly Cash Benefit		$966.46
B. LESS Cost of Direct Employment	(Section I)	$892.41
C. LESS Cost of Agency Services	(Section II)	$ -
D. LESS Cost of Other Expenses	(Section III, IV)	$ 70.00
E. LESS Cost of Fiscal Intermediary Services	(Section V)	$ 3.75
(A minus the sum of B, C, D & E)	MONTHLY BALANCE	$0.30

Decision Tree Completed: Yes___ No___

CMP Designed By:

Consumer Signature: _____ Date: 2/26/02

Representative Signature: _____ Date: _____

Consultant Review: _____ Date: 2/26/02

(Signature and Title)

Agency Name: _____ Phone# _____

State Program Office Approval: Renee Davidson _____ Date: 2/26/02

(Signature and Title)

PPPcmp 7/99:8/99 Revision#6

Appendix #3

Counselor/Participant form

COUNSELOR/PARTICIPANT MATCHES

Last Name	First Name	Address	City	Zip Code	Telephone	Consultant	Consultant's Telephone

Appendix 4

Quarterly Report

Department of Human Services
State Office On Disability Services
Personal Preference: New Jersey's Cash & Counseling Demonstration

CONSULTANT QUARTERLY REPORT

For Period of: _____(Month) _____(Year) Date Completed: _____/_____/____

Participant's Name: _____ SSN: _____-_____-_____

Number of Contact Hours this Quarter: _____Total Contact Hours to Date: _____

Telephone Contact Hours this Quarter: _____ In Person Visit Hours this Quarter: _____

1. Was there a change in address or phone number of the participant? Yes__ No__
   (If yes, please provide current information)

_____
_____

2. Were there any discrepancies between the Cash Management Plan/Client Records and reports from the Fiscal Intermediary this quarter? Yes__ No__
   (If yes, please describe briefly, how they were resolved, & estimated time expended)

_____
_____
_____

3. Was it necessary for you to contact or interact with the Fiscal Intermediary? Yes__ No__
   (If yes, please briefly describe issue, resolution & estimated time expended)

_____
_____
_____

4. Were any problems identified from the consumer's prospective? Yes__ No__
   If yes, please check appropriate item:
   - ____ Problem with Consultant ____ Problem with CMP
   - ____ Problem with Representative ____ Problem with FI

5. ___ Check here if you would like to confer with the Program Manager of the Personal Preference Program. You will be contacted for an appointment.

6. What is the consumers Workers Compensation Policy #_____ & policy expiration date _____?

Consultant Signature: _____ Date: _____

Agency: _____Phone Number:(_____)_____-_____